PRINTED: 04/29/2011 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPI	LETED
		155344	B. WING			03/28/2	2011
	PROVIDER OR SUPPLIE			STREET A	ADDRESS, CITY, STATE, ZIP CODE B HIGHWAY 20 EAST GAN CITY, IN46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX	1	NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F0000							
	This visit was for the Investigation of Complaint IN00087416.		F00	000	Note: This provider wishes this Pla		
					Correction to be considered as our credible allegation of compliance.		
	1				Preparation and/or execution of this	S	
	This visit was de	one in conjunction with			Plan of Corrections does not const		
		on and State Licensure			admission of agreement by the pro of the truth of the facts alleged or	vider	
	Survey.	on and State Electistic			conclusion set forth in the Stateme	nt of	
	Survey.				Deficiencies. The Plan of Correctio prepared and/or executed solely	n is	
	Commission DIOC	0007416 Chtttd			because it is required by the provis	ion of	
	1 ^	0087416 - Substantiated.			the Federal and State laws.		
	1	eficiencies related to the					
	1 -	ted at F223, F225, and					
	F226.						
	Dates of Survey	r: March 21, 22, 23, 24,					
	-						
	25, and 28, 2011	1					
	Facility Number						
	Provider Number						
	AIM Number:	100287700					
	Survey Team:						
	Heather Tuttle, 1	RN. TC.					
	Lara Richards, I						
	Janet Adams, R						
	Kathleen Vargas						
	Tawario on Yungus	,, 14 (
	Census Bed Typ	oe:					
	89 SNF/NF						
	89 Total						
	Census Payer Ty	wne.					
	24 Medicare	ypc.					
	56 Medicaid						
	i bo iviedicald		1		I		1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9YZS11

Facility ID:

000236

If continuation sheet

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
ANDILAN	or correction	155344	A. BUILDING	00	03/28/2011
NAME OF B			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	
	ROVIDER OR SUPPLIER			HIGHWAY 20 EAST	
	RE CENTER OF MI		MICHIC	GAN CITY, IN46360	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE DATE
	9 Other				
	89 Total				
	Sample: 40				
	These deficiencie	es also reflect state			
	findings cited in	accordance with 410 IAC			
	16.2.				
F0223	The resident has t verbal, sexual, phy	/11 by Suzanne Williams, RN he right to be free from ysical, and mental abuse, ent, and involuntary			
SS=D	The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure each resident was free from verbal abuse related to staff to resident verbal abuse as witnessed by a dietary employee for 1 of 4 allegations of abuse reviewed for 1 of 4 residents reviewed for abuse in the sample of 40. (Resident #B) Findings include:		F0223	F223 Resident B has been discharg from facility. The LPN is no lor employed by facility. 2.) All residents have the pote to be affected by the same deficient practice. Allegations cabuse will be reported to India Department of Healthand investigated by	ntial of
	was reviewed on 3/incident date was Sidescription of the ir in the dining room talking in a loud voor "because she was her watch." The immediate actinvestigation was significant to the immediate actinuous significant significant to the immediate actinuous significant significan	erbal abuse for Resident #B /25/11 at 10:30 a.m. The Sunday 9/26/10. The brief ncident was the resident was when a nurse (named), bice, told the resident to eat not going to lose weight on tion taken was an estarted, Executive Director e suspended, physician		investigated immediately by ED/Designee. The facility pol on "Reporting Alleged Abuse was amended to include "failure to report alleged abu immediately upon occurrence or allegation will result in corrective action." 3.) Staff win-serviced on 03/28/11, 04/06 and 04/12/11 on types of abuse reporting abuse, procedures of and investigation of abuse by	e" sse se se sas s/11

SENTERS FOI	WIEDICAKE & MEDIC	- SERVICES			OMB 110. 0250-0371	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED	
		1	A. BUILDING			
		155344	B. WING		03/28/2011	
		ш	STREET	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	PROVIDER OR SUPPLIE	R				
				S HIGHWAY 20 EAST		
LIFE CAI	RE CENTER OF M	ICHIGAN CITY	MICHIC	GAN CITY, IN46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID ID	i	(X5)	
				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	· · ·	
PREFIX	· `	NCY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	notified and family	y notified.		Nursing Administration. Staff	will	
	·			be in-serviced monthly for 3		
	The preventative	measures taken were to		months and quarterly		
		ce follow up with the resident				
		e staff on the abuse policy.		thereafter on reporting		
		stall of the abuse policy.		potential abuse immediately		
				ED/Designee. DON/Designee	•	
		ness interview form dated		will audit 24 hour report dail	y	
	,	etary employee who		M-F for potential abuse,		
		bal abuse indicated "I		incidents and accidents and		
	(name) observed	a staff member telling a		review resident, family and		
	resident that she	at least has to eat 50% of			.,	
	her dinner or she	couldn't be moved out of		staff complaints. The ED/DON		
		uld not go to bed. She also		is on call 24 hours a day. Th		
		gonna allow her to lose		weekend on call manager wi	II	
		tch. Then I left out of the		have her name posted on the	e	
	_			staff assignment sheet for		
		back to the kitchen. I came		immediate notification. All n	ow	
		dining room. I heard the		staff will be informed of abu	·	
		he always does) and the				
	same staff member	er (name) came into give		policies in orientation and in	1	
	meds and she asl	ked her to stop crying and if		ongoing education. 4.)		
	she doesn't, her a	aide will get mad at her and		Allegations of abuse will be		
	not put her to bed	_		reported to Performance		
				Improvement Committee mon	thly.	
	Paview of anothe	r witness interview dated		Tracking and trending will be	, I	
				monitored in Performance		
		etary supervisor on duty on		Improvement.5.) The DON is		
	,	ndicated "Dietary Aide			ina	
		sk me a question about if		responsible for ensuring ongo	"' ⁹	
		orce a resident to eat. She		compliance.Compliance date		
	stated that (name) told resident that she had		04/27/11.		
	to eat 50% of her	food or she would have to				
	sit up in dining roo	om she was not going to be				
		ner watch. She told me I had				
	to report to (name					
	Siepoit to (name	.,,,				
	Review of anotho	r witness statement dated				
		m. supervisor/cook indicated				
		10 (name) came to me about				
		witnessed on Sunday				
		me she had told (name)				
	supervisor/p.m., a	after she witnessed it.				
	1 '	lanager was not here and				
		supervisor would not be here				

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	TIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
ANDILAN	or correction	155344	A. BUILD	DING	00	03/28/2	
			B. WING	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY			GAN CITY, IN46360		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	•	old her we would not wait nt to (name) the ADON on					
		eported everything to her,					
	•	ments and said she would					
	investigate the matter.						
	Review of the Sus	pension Form indicated the					
		ed on 9/29/10 three days					
		Review of the Termination					
		10/4/10 the employee was					
	terminated from er	nployment.					
	Interview with the	DON on 3/25/11 at 11:30					
		e was not employed at the					
		t, and the Administrator at					
		onger employed at the further indicated the					
		I abuse was substantiated					
	by the facility.						
	This federal tag re	lates to complaint					
	11400007416.						
	3.1-27(b)						
F0225	The facility must n	ot employ individuals who	1				
	_	guilty of abusing, neglecting,					
		dents by a court of law; or gentered into the State					
		concerning abuse,					
		nent of residents or					
		of their property; and report					
	,	nas of actions by a court of					
		ployee, which would for service as a nurse aide					
		iff to the State nurse aide					
	registry or licensin						
	The facility was t	warre that all allers d					
		nsure that all alleged g mistreatment, neglect, or					

STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	NNC	00	COMPL	ETED
		155344	B. WING			03/28/20	011
			B. WING		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF PR	ROVIDER OR SUPPLIER				HIGHWAY 20 EAST		
LIFF CAR	E CENTER OF MI	CHIGAN CITY			SAN CITY, IN46360		
			,				710
(X4) ID		TATEMENT OF DEFICIENCIES	"	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	'	REFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Œ	COMPLETION DATE
			1	IAU			DATE
	•	njuries of unknown source ion of resident property are					
I		tely to the administrator of					
		other officials in accordance					
	with State law thro						
		ding to the State survey and					
	certification agend						
		ave evidence that all					
		are thoroughly investigated,					
	and must prevent further potential abuse while the investigation is in progress.						
	willio allo ilivoolige	ation to in progress.					
	The results of all i	nvestigations must be					
	reported to the administrator or his						
I .	•	entative and to other					
		ance with State law					
		tate survey and certification					
		vorking days of the incident, violation is verified					
		ctive action must be taken.					
	Based on recor		F02	25	F225		04/27/2011
		facility failed to ensure			Resident B allegations of abuse was investigated. The LPN is no		0 = , , = 0
	every allegation	-					
I .	reported immed				longer employed by the facility	' -	
	•	nd every resident was			Resident C allegation was		
I .					investigated. Resident receive counseling and psychiatrist	u	
	•	g the investigation for			services for her well being. Vis	sitor	
		ns of abuse reviewed			informed he could not enter	,,,,,,,	
		ents reviewed for			facility. No actual harm noted t	to	
	abuse in the sa	imple of 40. (Resident			either resident.		
	#B and #C)				2 All residents have the potent		
					to be affected by alleged defici		
	Findings includ	e:			practice. Allegations of abuse	WIII	
					be reported to Indiana Department of Health and		
	1. Review of th	ne Fax/Incident Report			investigated immediately by		
		ndicated Resident #C			ED/Designee. The facility policy		
		or (name) sat on the			on "Reporting Alleged Abuse	-	
II		to talk to her on			was amended to include		
					"failure to report alleged abu	se	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			(X3) DATE SURV	VEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIC	00	COMPLETEI	D
		155344	A. BUIL			03/28/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	1					
	DE OENTED OF M	OLUGAN OLTV			HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		MICHIG	GAN CITY, IN46360		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		re CO	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Sunday evenin	g. During this time she			immediately upon occurrenc	e	
	•	her and patted her			or allegation will result in		
		stating that she took			corrective action." 3.) Staff w	as	
		(Name) then stated			in-serviced on 03/28/11, 04/06		
		•			and 04/12/11 on types of abus		
	` '.	nis penis out of his			reporting abuse, procedures of	f	
		his penis to her. The			and investigation of abuse by		
		that the nurse (name)			Nursing Administration. Staff v	VIII	
	walked in and	saw the visitor sitting			be in-serviced monthly for 3 months and quarterly		
	on the foot of h	er bed and the nurse			thereafter on reporting		
	(name) asked t	he visitor to leave the			potential abuse immediately	to	
	building.				ED/Designee. ED/DON will		
	bananig.				audit 24 hour report daily M-	_	
	A full body coo	acoment was			for potential abuse, incidents		
	A full body asse				and accidents and review	'	
	-	he resident, and there			resident, family and staff		
		injuries. Urine was			complaints. The ED/DON is o	on	
	collected, and t	the urinalysis was			call 24 hours a day. The	.	
	positive for a U	TI (urinary tract			weekend on call manager wi	ıı	
	injection) and a	n antibiotic was			have her name posted on the		
	started.				staff assignment sheet for		
	0.0				immediate notification. All no	∍w	
	Immodiato Acti	on taken was both			staff will be informed of abus	ie	
					policies in orientation and in		
		interviewed, family			ongoing education.		
		nysician notified. The			4.) Allegations of abuse will be	;	
	visitor was ask	ed not to come into the			reported to Performance		
	building during	the investigation. A			Improvement Committee mon		
	police report wa	as made and the police			5.) The DON is responsible fo		
	investigation st	arted. Staff was			ensuring ongoing compliance. Compliance date 04/27/11.		
	_	n abuse. An inservice					
		for after hours visitors.					
	was also givell	ioi ditoi nodia vialtora.					
	Duay tamén ting ting	a a a uma a dalca a a a a a a					
		easures taken were					
		were immediately					
	separated, one	to the other side of					
	the building. S	taff monitored					
	Resident #C, a	nd referrals were made					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155344	B. WIN			03/28/2	011
NAME OF I	DD OTHDED OD GUDDI IEI		!	STREET A	ADDRESS, CITY, STATE, ZIP CODE	ļ.	
NAME OF I	PROVIDER OR SUPPLIEI	C		802 US	HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF M	CHIGAN CITY			GAN CITY, IN46360		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	-	TAG	DLI ICILIACI)		DATE
		seling and a psychiatrist					
	1	C's well being. The					
	1	indicated they were					
	1	tantiate allegations,					
		investigation continues.					
		nitial and follow up					
	report.						
	Review of witn	ess statements by the					
	CNA who was	taking care of Resident					
	#C that night in	ndicated "A man came					
	in to visit (nam	e) (Resident #C's					
	roommate). Th	e man was her son,					
	when he came	in he said 'Hi' then he					
	just stood by th	ne door and watched					
	1 -	lking to (name) mother.					
	1	ore this, one of the day					
	1	hat (Resident #C) said					
	1	roommate's visitors					
	came and tried	to kiss her. So when I					
	seen her son c	ome in I kept an eye					
	1	ing happened. When a					
	1	on, I told the nurse					
	1	had told me and that if					
		eep an eye on them					
	1	get the call light. It					
	1	eir safely because I					
	1 -	at was going on or					
		s the visitor that was					
		s. When I got back out					
	1	at I was giving care to,					
	1	me he had to ask the					
		ecause he tried to kiss					
		Again I have not seen					
	1 '	yself. So I then went to					
	1 2017 0 1119 101 111	Joon Co I alon Work to					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i i i i i i i i i i i i i i i i i i i			(X3) DATE S	
AND PLAN	OF CORRECTION	155344	A. BUI	LDING	00	COMPL 03/28/2	
		133344	B. WIN	_		03/20/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		1	HIGHWAY 20 EAST GAN CITY, IN46360		
					JAN 611 1, 114 4 0000		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CV MUST BE REDGEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
) room to check on her	+				5.112
	'	ate. They acted fine					
		sident #C) if she					
	,	lp into her night-gown.					
	•	out she had already					
	changed into o	-					
	_	pegan to help her back					
		she said, 'That man					
		.' and I said 'I know					
		nurse asked him to					
	_	thing else happen?'					
	She then answered 'No'. After						
		e was fine, I began to					
	_	n said, 'He tried to					
		ed her what do you					
	-	aid 'He tried to kiss me.'					
	So I went out to	tell the nurse and he					
		ed to kiss (name) and					
	_	he told him he had to					
	leave.' With me	e not seeing anything, I					
	told my supervi	sor what I heard. Then					
	he was the one	that seen the action."					
	Review of the v	vitness statement from					
	the RN on duty	that evening indicated					
	"The time would	d have been around 7					
	p.m. Sunday, S	September 19, 2010.					
	Sometime durir	ng the beginning of my					
	med pass a CN	IA came up to me and					
	,	#C) said that her					
	roommate's soi	n wants to kiss her.					
	The aide then f	ollowed with 'but you					
		es (Resident #C) gets					
		ntinued to pass a med					
	or two then wer	nt to their room. When					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155344	B. WIN			03/28/2011
NAME OF I	DROWIDED OD SLIDDI IED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			802 US	HIGHWAY 20 EAST	
	RE CENTER OF MI	CHIGAN CITY		MICHIG	GAN CITY, IN46360	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)	DATE
		oom the resident's				
		s were wide open and				
) roommate introduced				
	•	on't remember his				
	,	ent #C) was sitting in				
	· ·	dresser and this man				
	_	bout 4-5 feet away				
		the bed with a night				
	•	nd facing the resident.				
		of place because his				
	mother was alre	eady in bed, and he				
	was not facing	towards his mother as				
	if to assist her.	He was fully clothed,				
	and I did not se	ee his penis exposed. I				
	noticed a strong	g odor of etoh				
	(alcohol). I tolo	I him my name and as				
	precaution and	I told him he would				
	have to leave n	low. He put the				
	nightgown dow	n and left and I don't				
	recall him sayir	ng anything to me or				
	his mother on t	he way out. I looked				
		d saw this guy walking				
		oward main entrance.				
	I helped (Resid	ent #C) with her				
	. ,	continued my med				
	pass."	•				
	•					
	Review of anot	her witness statement				
	by the Assistan	t Director of Nursing at				
	_	ated on 9/20/10				
		lent #C had reported to				
		ommate's son tried to				
		ght. She then reported				
	-	o the Director of				
	Nursing.	0 1.10 Director of				
	i tui sii ig.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE S COMPL 03/28/20	ETED	
NAME OF I	PROVIDER OR SUPPLIEF		802 US	ADDRESS, CITY, STATE, ZIP CODE 5 HIGHWAY 20 EAST	•	
LIFE CA	RE CENTER OF MI	CHIGAN CITY	MICHIC	GAN CITY, IN46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
	the incident was r Administrator or t	estigation report indicated not reported promptly to the he Director of Nursing. ursing was notified at 3:30				
	3/25/11 at 12:30 p the Director of Nu incident. She also had also left the fa elsewhere. The D the allegation of a timely to the Admi	Director of Nursing on o.m., indicated she was not ring at the time of the o indicated the Administrator acility and was employed birector of Nursing indicated buse was not reported inistrator or the Director of the allegation of sexual ditimely.				
	Resident #B was a 10:30 a.m. The in 9/26/10. The brief was the resident was urse (named),	of verbal abuse for reviewed on 3/25/11 at incident date was Sunday description of the incident was in the dining room when talking in a loud voice, told to because she was not which the on her watch."				
	investigation was	tion taken was an started, Executive Director suspended, physician notified.				
	have Social Servi	measures taken were to ce follow up with the resident staff on the abuse policy.				
	9/29/10 by the die witnessed the ver (name) observed resident that she a	ness interview form dated tary employee who bal abuse indicated "I a staff member telling a at least has to eat 50% of couldn't be moved out of				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2 AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED				
AND PLAIN	OF CORRECTION	155344	A. BUI			03/28/2	
		100044	B. WIN		A PARAGO CITAL CTATE TIN CORE	00/20/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 20 EAST		
LIFE CAF	RE CENTER OF MI	CHIGAN CITY		1	GAN CITY, IN46360		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG			+	TAG	DEFICIENCY)		DATE
TAG	dining room or coustated she wasn't weight on her wated dining room to go back to clean the cresident crying (she same staff member meds and she ask she doesn't, her ainot put her to bed. Review of another 9/29/10 by the died Sunday 9/26/10 in (name) want to assomeone could for stated that (name) to eat 50% of her fisit up in dining roomal weight loss on her to report to (name) Review of another 9/30/10 by the a.m on Monday 9/27/10 some abuse she we 9/26/10. She told supervisor/p.m., at (Name) Dietary Ma (name) the p.m., s Monday either. It for them so we we	ald not go to bed. She also gonna allow her to lose ch. Then I left out of the back to the kitchen. I came dining room. I heard the e always does) and the er (name) came into give ed her to stop crying and if de will get mad at her and " witness interview dated tary supervisor on duty on dicated "Dietary Aide k me a question about if the a resident to eat. She told resident that she had food or she would have to m she was not going to be er watch. She told me I had		TAG		TE	DATE
	she took her stated investigate the ma	ments and said she would tter.					
	LPN was suspend after the incident.	pension Form indicated the ed on 9/29/10 three days Review of the Termination 10/4/10 the employee was mployment.					

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	ON (X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155344	B. WING		03/28/2011	
		_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t .		S HIGHWAY 20 EAST		
LIEE CAE	RE CENTER OF MI	CHICAN CITY		GAN CITY, IN46360		
LIFE CAP	KE CENTER OF WII	CHIGAN CITT	IVIICHI	GAN CITT, IN40300		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		witness forms and the				
	•	tion form indicated they all				
	had the date of 9/29/10 (three days after the					
	allegation had hap	opened and was witnessed).				
	Poviow of the staf	ffing sheet for 9/26/10				
		that had allegedly made				
		to the resident was not				
		ved from the facility and				
	continued to work.	-				
		DON on 3/25/11 at 11:30				
		e was not employed at the				
		nt, and the Administrator at				
		onger employed at the				
	,	indicated the Administrator				
		f Nursing at the time, were				
		of the allegation of verbal er indicated the LPN did not				
		nmediately and continued to				
		ne shift. The DON further				
		gation of verbal abuse was				
	substantiated by the					
		,				
	This federal tag re	elates to complaint				
	IN00087416.					
	3.1-28(c)					
	3.1-28(d)					
F0226	The facility must o	develop and implement				
10220	•	nd procedures that prohibit				
	·	glect, and abuse of residents				
		tion of resident property.				
SS=D		review and interview, the	F0226	F226	04/27/2011	
		follow their Abuse Policy		Resident B allegation of abuse was		
	related to promp	-		investigated and the LPN is no long employed by the facility.Resident C		
				allegation of abuse was investigated		
		egations of sexual and		and visitor informed he could not er	iter	
	verbal abuse and	l ensuring the residents	1	facility again. Resident received ser	nior	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155344				03/28/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1			
LIEE OA		IOLUO ANI OLTV		1	HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF M	ICHIGAN CITY		MICHIC	GAN CITY, IN46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	were protected f	from further abuse, for 2			counseling and psychiatric services		
	of 4 allegations	reviewed for abuse for 2			her well being. No actual harm note either resident.	d to	
	1	viewed for abuse in the			All residents have the potential to	be	
		Resident #B and #C)			affected by the same deficient		
	sample of 40. (I	Resident #B and #C)			practice.Allegations of abuse will be		
					reported to Indiana Department of Health and investigated immediately	/ hv	
	Findings include	2:			ED/Designee. The facility policy or		
					"Reporting Alleged Abuse" was		
	Review of the	current and undated			amended to include "failure to rep	ort	
	Reporting Alle	ged Abuse Policy,			alleged abuse immediately upon occurrence or allegation will resul	t in	
		e Director of Nursing,			corrective action."	•	
	1 '	personnel, resident,			3.) Staff was in-serviced on 03/28/1	1,	
		isitor are encouraged to			04/06/11 and 04/12/11 on types of abuse, reporting abuse, procedures	of	
		_			and investigation of abuse by Nursii		
	1	t incidents of suspected			Administration. Staff will be	3	
		and/or neglect to			in-serviced monthly for 3 months	and	
	facility adminis	tration. All alleged or			quarterly thereafter on reporting potential abuse immediately to		
	suspected viol	ations involving			ED/Designee. DON/Designee will		
	mistreatment,	abuse, neglect, injuries			audit 24 hour report daily M-F for		
	of unknown or	igin (e.g. bruising and			potential abuse, incidents and		
		be promptly reported to			accidents and review resident, fan	-	
	1	tor and/or director of			and staff complaints. The ED/DON on call 24 hours a day. The weeke		
					on call manager will have her nam		
		person observing an			posted on the staff assignment sh		
		esident abuse or			for immediate notification. All new staff will be informed of abuse		
		ident abuse will			policies in orientation and in ongo	ina	
	immediate suc	h incidents to their			education.	9	
	immediate sup	ervisor and/or charge			Allegations of abuse will be reported		
	nurse. The su	pervisor and/or charge			Performance Improvement Committ	ee	
	nurse will illicit				monthly. The DON is responsible for ensuring	g	
		en the incident is			ongoing compliance. Compliance de	•	
		name of the resident,			is 04/27/11.		
	1 .	me of the incident,					
		·					
		dent took place, the					
		persons committing or					
	involved with t	he incident and the					
	name of any w	ritnesses. If the					
	1		1				

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 03/28/2	ETED
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				1	HIGHWAY 20 EAST		
	RE CENTER OF MI			L	GAN CITY, IN46360		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PREEIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
PREFIX TAG	accused individe they will be plated pending results while the incide investigated. 1. Review of the dated 9/19/10 is stated that visit side of her bed Sunday evening said he kissed stomach area, care of herself. (name) pulled I pants exposing resident stated walked in and son the foot of her (name) asked to building. A full body assecompleted for the were no noted collected, and positive for a Universal stated walked in and son the foot of herself.	dual is an employee, ced on suspension of the investigation ent is being e Fax/Incident Report andicated Resident #C for (name) sat on the to talk to her on g. During this time she her and patted her stating that she took (Name) then stated his penis out of his penis to her. The that the nurse (name) saw the visitor sitting fer bed and the nurse the visitor to leave the		PREFIX TAG		TE .	COMPLETION DATE
	Immediate Acti residents were notified, and ph visitor was ask	on taken was both interviewed, family hysician notified. The ed not to come into the the investigation. A					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155344		A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 03/28/2	ETED	
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					HIGHWAY 20 EAST		
	RE CENTER OF M			MICHIG	GAN CITY, IN46360		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION DATE
1710	1	as made and the police	-	1/10			DITTE
	1 '	arted. Staff was					
	_	n abuse. An inservice					
		for after hours visitors.					
	Preventative m	easures taken were					
	the roommates	were immediately					
	1 '	to the other side of					
	the building. S						
	1	ind referrals were made					
		seling and a psychiatrist					
	1	C's well being. The					
	1	indicated they were					
	1	tantiate allegations, investigation continues.					
	1	nitial and follow up					
	report.	illiai and follow up					
	1.000.11						
	Review of witn	ess statements by the					
	CNA who was	taking care of Resident					
	#C that night ir	ndicated "A man came					
	,	e) (Resident #C's					
	1 '	e man was her son,					
		in he said 'Hi' then he					
	1 -	ne door and watched					
	1	lking to (name) mother.					
	1	ore this, one of the day					
	1	hat (Resident #C) said roommate's visitors					
		to kiss her. So when I					
		ome in I kept an eye					
		ing happened. When a					
		on, I told the nurse					
	1	had told me and that if					
		eep an eye on them					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155344	B. WIN		-	03/28/2	011
		ш			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF MI	CHIGAN CITY		1	GAN CITY, IN46360		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		get the call light. It					
		eir safely because I					
		at was going on or					
	even if that wa	s the visitor that was					
	coming on day	s. When I got back out					
	of the room that	nt I was giving care to,					
	the nurse told i	me he had to ask the					
	man to leave b	ecause he tried to kiss					
	(Resident #C).	Again I have not seen					
	anything for my	yself. So I then went to					
	(Resident #C's) room to check on her					
	and her roomn	nate. They acted fine					
	so I asked (Re	sident #C) if she					
	· ·	lp into her night-gown.					
	1	but she had already					
	changed into o	-					
	1	began to help her back					
	• •	she said, 'That man					
		e.' and I said 'I know					
		nurse asked him to					
	1	thing else happen?'					
		ered 'No'. After					
		ne was fine, I began to					
	1	en said, 'He tried to					
		ked her what do you					
	1 '	aid 'He tried to kiss me.'					
		o tell the nurse and he					
		ed to kiss (name) and					
	1	o he told him he had to					
		e not seeing anything, I					
		0 , 0					
		isor what I heard. Then that seen the action."					
	i ne was the one	e mat seen me action.					
	Dovious of the	witness statement from					
	Line Kin on auty	that evening indicated					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 03/28/2	ETED
NAME OF I	PROVIDER OR SUPPLIEI	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF	FROVIDER OR SUFFLIE	· ·		1	HIGHWAY 20 EAST		
LIFE CA	RE CENTER OF M	CHIGAN CITY		MICHIG	GAN CITY, IN46360		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		d have been around 7					
		September 19, 2010. ng the beginning of my					
		NA came up to me and					
	•	#C) said that her					
	,	n wants to kiss her.					
		followed with 'but you					
		es (Resident #C) gets					
		ontinued to pass a med					
	or two then we	nt to their room. When					
	I entered the ro	oom the resident's					
	1 '	s were wide open and					
	1 ') roommate introduced					
	· ·	lon't remember his					
	,	ent #C) was sitting in					
	1	e dresser and this man					
		bout 4-5 feet away					
		f the bed with a night					
	~	nd facing the resident.					
		of place because his					
		eady in bed, and he towards his mother as					
		He was fully clothed,					
		ee his penis exposed. I					
	noticed a stron						
		d him my name and as					
	· '	I I told him he would					
	1 '	now. He put the					
	1	n and left and I don't					
	recall him sayi	ng anything to me or					
	1	the way out. I looked					
		nd saw this guy walking					
		toward main entrance.					
	1 ' '	lent #C) with her					
	nightgown and	continued my med					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A DIHI DDIG 00			COMPLETED	
	1553 <i>44</i>		A. BUII			03/28/2	2011	
		1.555.1	B. WIN			100/20/2		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
					HIGHWAY 20 EAST			
LIFE CA	RE CENTER OF M	ICHIGAN CITY		MICHIG	GAN CITY, IN46360			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG	+	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
	pass."							
	Daview of one	th ar with an a statement						
		ther witness statement						
	1 -	nt Director of Nursing at						
		cated on 9/20/10						
		dent #C had reported to						
		ommate's son tried to						
	kiss her last ni	ght. She then reported						
	the allegation t	to the Director of						
	Nursing.							
	Review of the inv	estigation report indicated						
		not reported promptly to the						
		the Director of Nursing.						
		ursing was notified at 3:30						
	p.m. on 9/20/11.							
	Interview with the	Director of Nursing on						
		p.m., indicated she was not						
		ursing at the time of the						
		o indicated the Administrator						
	had also left the f	acility and was employed						
	elsewhere. The [Director of Nursing indicated						
	the allegation of a	abuse was not reported						
	1 '	inistrator or the Director of						
		the allegation of sexual						
	abuse investigate	ed timely.						
	2. The allegation	of verbal abuse for						
	_	reviewed on 3/25/11 at						
		incident date was Sunday						
	9/26/10. The brief	f description of the incident						
	was the resident	was in the dining room when						
		talking in a loud voice, told						
		t "because she was not						
	going to lose weig	ght on her watch."						
	The immediate a	ction taken was an						
		started, Executive Director						
	1	e suspended, physician						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					INSTRUCTION 00	(X3) DATE : COMPL	
		155344	A. BUII B. WIN			03/28/2	011
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		_	ADDRESS, CITY, STATE, ZIP CODE	l	
				I	HIGHWAY 20 EAST		
	RE CENTER OF MI				GAN CITY, IN46360		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	notified and family	notified.					
	have Social Servi	measures taken were to be follow up with the resident staff on the abuse policy.					
	9/29/10 by the die witnessed the verl (name) observed a resident that she a her dinner or she dining room or constated she wasn't weight on her wat dining room to go back to clean the resident crying (she same staff member meds and she ask	ness interview form dated tary employee who coal abuse indicated "I a staff member telling a sat least has to eat 50% of couldn't be moved out of couldn't be moved out of could not go to bed. She also gonna allow her to lose ch. Then I left out of the back to the kitchen. I came dining room. I heard the ne always does) and the er (name) came into give sed her to stop crying and if ide will get mad at her and "."					
	9/29/10 by the die Sunday 9/26/10 in (name) want to as someone could fo stated that (name) to eat 50% of her sit up in dining roc a weight loss on h to report to (name Review of another 9/30/10 by the a.n	witness statement dated n. supervisor/cook indicated					
	on Monday 9/27/1 some abuse she v 9/26/10. She told supervisor/p.m., a (Name) Dietary M	0 (name) came to me about witnessed on Sunday me she had told (name) fter she witnessed it. anager was not here and supervisor would not be here					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155344	B. WIN			03/28/2	011
NAME OF F	PROVIDER OR SUPPLIEF	8	•		DDRESS, CITY, STATE, ZIP CODE HIGHWAY 20 EAST	•	
LIFE CAF	RE CENTER OF MI			1	SAN CITY, IN46360		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		told her we would not wait	+	IAG			DAIL
		ent to (name) the ADON on					
		reported everything to her, ments and said she would					
	investigate the ma						
	Review of the Sus	spension Form indicated the					
	•	led on 9/29/10 three days					
		Review of the Termination 10/4/10 the employee was					
	terminated from e						
	Review of all the v	vitness forms and the					
		tion form indicated they all					
		29/10 (three days after the opened and was witnessed).					
	anegation had hap	pperied and was withessed).					
		fing sheet for 9/26/10					
		that had allegedly made to the resident was not					
		ved from the facility and					
	continued to work						
		DON on 3/25/11 at 11:30					
		e was not employed at the nt, and the Administrator at					
		onger employed at the					
	facility. The DON	indicated the Administrator					
		f Nursing at the time, were					
		of the allegation of verbal er indicated the LPN did not					
		nmediately and continued to					
		e shift. The DON further					
	indicated the alleg substantiated by t	ation of verbal abuse was he facility.					
		•					
	This federal tag re IN00087416.	elates to complaint					
	3.1-28(a)						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	(X2) MULTIPLE CO A. BUILDING B. WING	00	l i	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		802 US	ADDRESS, CITY, STATE, ZIP CO HIGHWAY 20 EAST BAN CITY, IN46360	ODE	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	RESOLUTION ON	Doe 10 DENTI 1 1 1 1 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1				J. II.